Health Overview and Scrutiny Committee

Overview of Integrated care programme

June 2022

Achievement highlights Oxfordshire 2021 - 2022

Caring for patients with Covid at home

Provision of pulse oximetry at home for those patients most at risk of becoming seriously unwell after a positive Covid-19 diagnosis. Oxfordshire contributed to **South East onboarded 21,903 patients** onto a Covid-19 oximetry pathway which was the highest number of any region in England.

Developing community care to proactively manage high risk patients

Pilot with Bicester GP's and community team to develop an wider team with Health Care Professionals that could be replicated across Oxfordshire, to proactively assess and agree treatment plans for high risk patients within that area.

Infection prevention and control

Providing infection prevention and control support and advice to all providers.

Virtual wards

Accelerating the adoption and delivery of virtual wards to enable more care closer to home

Urgent Community Response

Urgent Community Response (UCR) supported patients to have their initial assessment in their own home and supported to remain at home.

Health and social care integration

Oxfordshire social care and health providers worked together and with the voluntary sector to simplify processes to support patients being discharged from bed based care.

Multi-professional leadership

Multi-professional leadership across organisational and sector boundaries. Health providers working together with to improve integration and joint working across all pathways and vaccination. Virtual, telephone and face to face assessments carried out.

Communications

Social media and online advertising to promote the differences between urgent and emergency care with targeted digital campaign to those who live near to MIUs.

NHS 111 online has been promoted in addition to pharmacy opening hours.

Primary Care achievements Oxfordshire 2021 - 2022

Winter Access Funding available from November 2021 – March 22 provided

- 2,427 additional GP sessions (a morning or afternoon surgery)
- 38,832 additional GP appointments
- 4,874 additional hours provided by other clinicians
  - 14,622 additional clinician (non GP) appointments
  - 9,413 additional hours of reception staff time

- Increase in GP appointments in March 22 by 15% compared to Feb 22
- Increase in both F2F and telephone appointments
- 52.2% of all appointments F2F
- Staff sickness due to COVID reduced in April 22

End of Life (EOL)

The Home Hospice Care team (HHCT) launched on 1st April 2022. Oxfordshire is committed to delivering a consistent specialist EOL service across all postcodes. To date the average time in service for all discharges, including deaths, was 7 days. The average age of patients is 80yrs.

PML PRINCIPAL MEDICAL

NHS South Central Ambulance Service NHS Foundation Trust

NHS Oxford Health NHS Foundation Trust

OXFORDSHIRE COUNTY COUNCIL

NHS Oxfordshire Clinical Commissioning Group

NHS Oxford University Hospitals NHS Foundation Trust

SCAS as a Care Navigator

A core theme of our strategic development has been to fill in the gaps and provide, or link, services within a developing health care system.

We now play a pivotal role in integrating care, as we interface with each and every part of our local care systems and we do this by

- Simplifying access to care
- Assessing more people remotely
- Enhancing mobile diagnostics and care
- Integrating care pathways
- Sharing learning across systems

Our SWOT

As we considered our future direction we also evaluated our Strengths, Weaknesses, Opportunities and Threats (SWOT).

Our SWOT helps us to better understand the context within which we operate. We identified a number of factors that would help us to develop our strengths and opportunities and mitigate our risks.

STRENGTHS

- We are a **Clinically Led** Trust with strong **Performance**
- Our **Financial Management** is robust and delivers sustainability
- **Innovation** is core to the ongoing development of our organisation
- We have developed our ability for **Partnership Working** and Co Design
- We have a strong **Brand & Reputation** driven by our performance culture
- Our **Workforce** is our core attribute, fully committed to our organisation

WEAKNESSES

- Our **Capacity & Capability** will be compromised if we do not develop our staff
- Slow change within the NHS can create a Lack of agility and resistance to development can compromise our **"Speed to Market"**
- **Attrition** limits our ability to develop a sustainable workforce
- **Funding Gaps** could limit our ability to be innovative
- Our **Estates** are in places tired and not fit for purpose
- Our **IT Infrastructure** needs investment

OPPORTUNITIES

- **New Working Alliances** will develop as systems integrate
- **Service Development opportunities** will arise as we evolve our core services
- **System Influence & Partnership** Working will enable our inclusion in system wide development
- New **Operating Model Designs** and synergies will be a natural result of service development
- **Operational Flex** will enable adaptation and redevelopment
- Our **Business Intelligence** as a system wide provider is a key asset

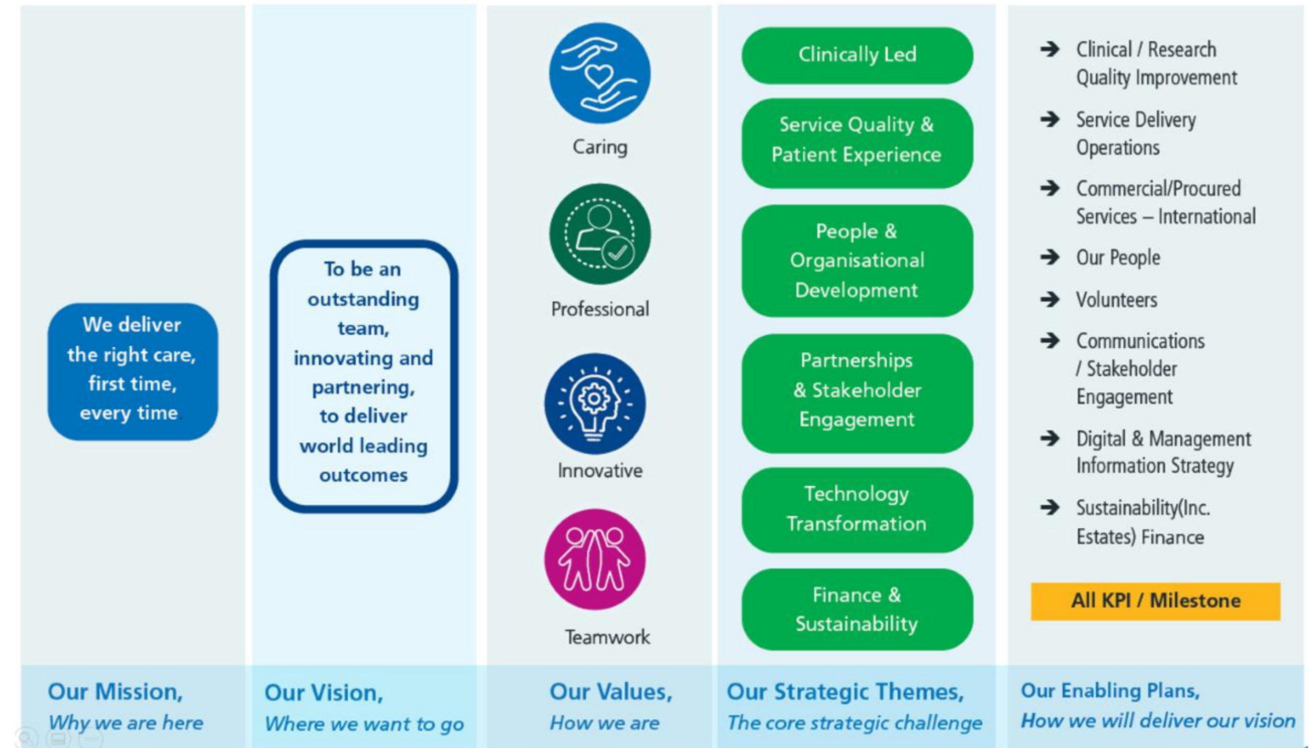
THREATS

- **Competition** Impact may stifle investment in services
- **Financial Stability & Partner Providers** may not be reliable as the health economy changes impacting our ability to deliver
- The relationship between changing **Capacity & Demand** could impact our performance
- Our **Workforce Capacity** and **Sustainability** will be limited if their resilience suffers post Covid
- The competition for our **Workforce** and resource **Availability**
- Political & Regulatory change may challenge our operating model

Major SCAS Transformation projects

- Move towards Regional Single Virtual Call Center to optimise call answer and routing.
- New booking and referral standard to enhance patient management.
- Development of Clinical Assessment Service which will provide better patient outcomes.
- Partnership working and collaboration to fulfil our role as a system integrator – streamlining referral routes and improved access to pathways.
- Launch of 5-year strategy we fulfill our mission statement to ensure we deliver the right care, first time, every time.

2022 – 2027 SCAS Strategy

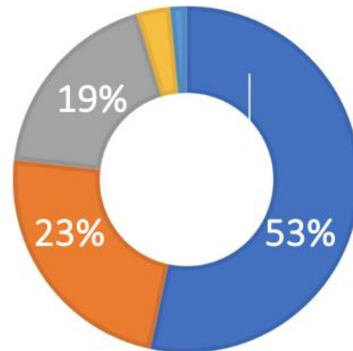


Integrated working with voluntary and community sector (VCS)

ASC referral pilot to Community Information Network

- Building on successes of Age UK Discharge Support Team
- **1,088** referrals May 21 - Mar 22
- People who would otherwise be on waiting list
- Reasons for referral: **social support** (companionship, groups, activities); **practical support** (shopping, cleaning, dog-walking, transport); **financial and benefits**

- **53% people** needed no further ASC input
- **23%** people 'co-worked'
- **19%** required ASC



Move Together

- Embedded in District Councils, providing behavior change, motivational interviewing and signposting to movement/PA.
- **1,199** total engagement to date
- Reach = **68%** aged 50+, **83%** negatively impacted by Covid-19, **43%** inactive around half living with a LTHC
- Impact - **70%** increase in active minutes, **40%** reduction in loneliness, **32%** improvement in pain/discomfort.
- Referrals from hospital Discharge Teams, GPs, ASC Locality Teams, SP's, Community Health and through self-referral.

Challenges to patient flow

Pathway 0 is where patients are discharged with no ongoing support.

Oxfordshire performs better than the national average.

However on pathway 1 where patients require additional support to return home Oxfordshire performs below the national average.
Pathway 2 is where patient are transferred to be based rehabilitation, Oxfordshire transfers more people to this pathway than the national average
Pathway 3 is where patients are transferred to long term placements, Oxfordshire is close to the national average.

Key highlights:

Demand has increased for patients requiring reablement following discharge from bed based care.

Challenges with workforce pressures have resulted in pick up rate from bed based care performed below expected levels.

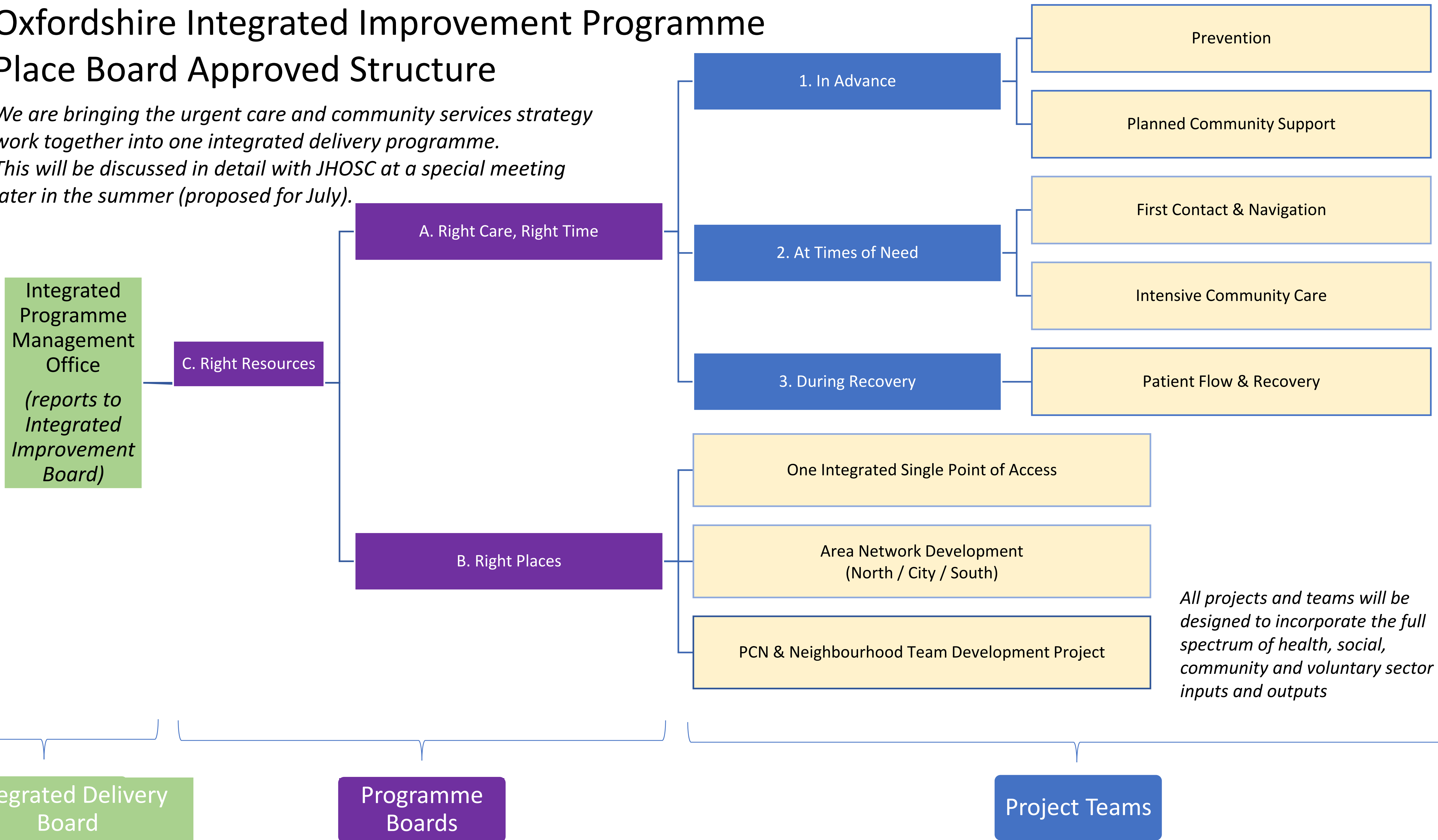
Oxfordshire is exceeding the performance indicator for the number of people achieving independence - 85% have no ongoing formal support needs.

Both Emergency Departments continued to be under pressure throughout 2021/2022. Attendances increased and the departments managed Covid and non covid demand.

The ambulatory units in the OUHFT and community saw a gradual increase in demand. All units experienced an increase in call volumes from health care professionals seeking advice before patients were conveyed for assessment.

Oxfordshire Integrated improvement programme

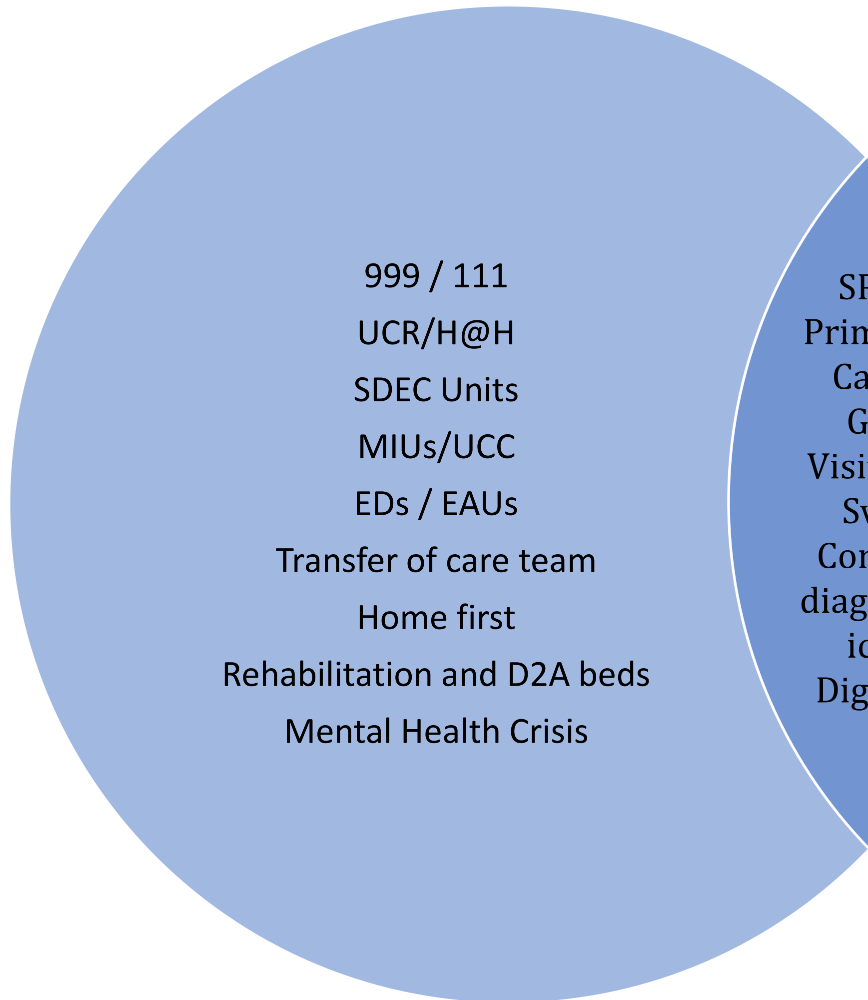
April 2022 - March 2023

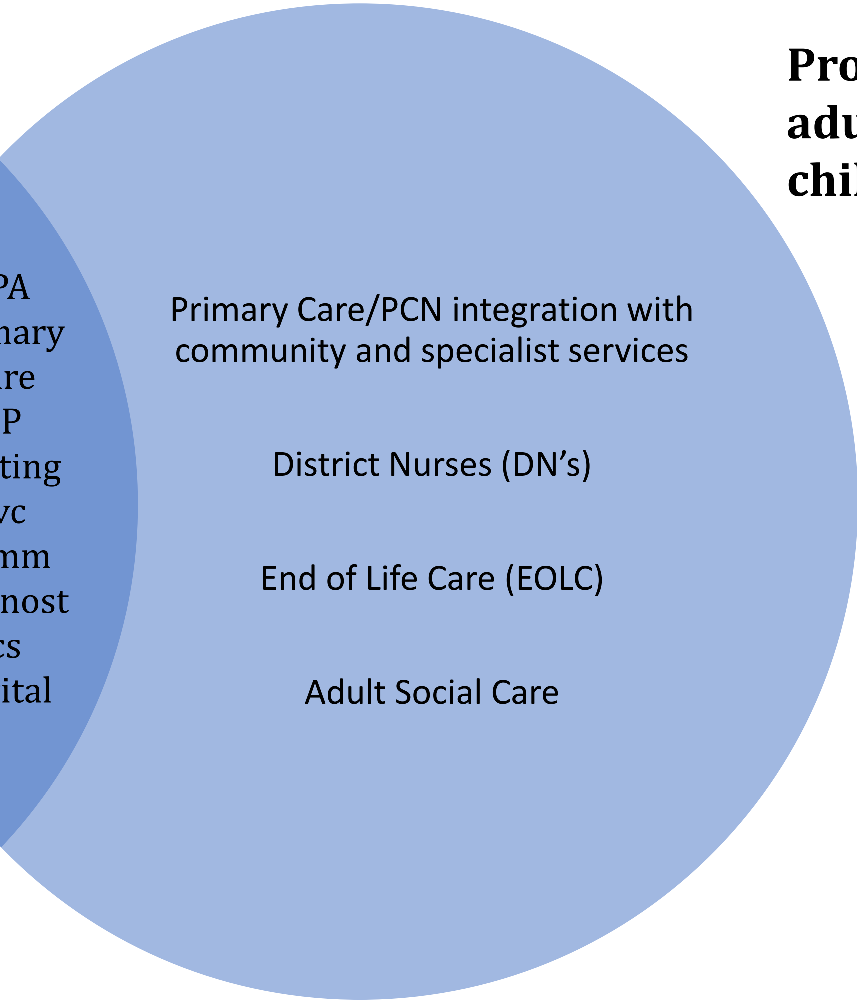

Oxfordshire Integrated Improvement Programme
Place Board Approved Structure
We are bringing the urgent care and community services strategy work together into one integrated delivery programme.
This will be discussed in detail with JHOSC at a special meeting later in the summer (proposed for July).
Integrated Programme Management Office
(reports to Integrated Improvement Board)
C. Right Resources
A. Right Care, Right Time
B. Right Places
1. In Advance
2. At Times of Need
3. During Recovery
Prevention
Planned Community Support
First Contact & Navigation
Intensive Community Care
Patient Flow & Recovery
One Integrated Single Point of Access
Area Network Development
(North / City / South)
PCN & Neighbourhood Team Development Project
All projects and teams will be designed to incorporate the full spectrum of health, social, community and voluntary sector inputs and outputs
Integrated Delivery Board
Programme Boards
Project Teams

Oxfordshire Services –overlap between community and urgent care

Same day/next day – adults and children

Proactive care - adults and children





Integrated Improvement Programme –Priority 1

- **Prevention - planned community support**
- **Virtual Care**
- **Keeping people safe at home**

Prevention - planned community support

P1.1 Prevention – planned care

- **Rationale:** Patients can be safely managed at home within the community setting
- **Benefits:** Manges patients in their own home improving peoples experience, wellbeing and promoting independence.
- **Expectation:**
- Develop an a list of criteria that help to identify people who are high risk
- High people are assessed in their own home and care plans developed to reduce their risk of deterioration/falls and to promote independence
- Patients who have complex needs are identified during discharge planning and have plans in place with community team before they leave hospital to ensure they have the correct follow up following discharge

P1.2 Development of MDT within a GP practice or Primary Care Network (PCN)

- **Rationale:** The MDT within a GP surgery/PCN have the required health Care Professionals (HCP's) to meet the needs of high risk patients
- **Benefits:** Improving outcomes for people and reducing the risk of further deterioration
- Developing plans that meet the patients needs and the level of intervention they have agreed to.

- **Expectation:**
- Each GP surgery/PCN haver an MDT membership that represented community nursing, pharmacy, therapy, social prescribing and social care
- The MDT meets daily/weekly to review people who are requiring additional oversight, assessment or treatment to maintain them safely in their own home
- Appropriate patients have care plans and anticipatory care plans in place

P1.3 End of Life

- **Rationale**: Single approach to the planning and management of EOL in Oxfordshire

- **Expectation**:

- Single referral process
- Consistent delivery of specialist EOL care across Oxfordshire
- Anticipatory planning
- Maintaining people in the place they wish to remain for EOL care
- Development of the RIPEL and Respect projects

NHS

Virtual care

P1.1 Developing a community team

- **Identification of high risk patients**
- Develop community teams with the skill set required to meet the populations needs
  - Community teams to comprise of the following: care co-ordinator, mental health practitioner, community gerontologist, GP, Social Worker, voluntary sector, community pharmacist and community nursing.
  - Using key variables to identify those who are high risk at home and have an initial assessment to determine their needs and feedback to daily/weekly MDT.
- Daily MDT with community teams to prioritise new referrals, complex hospital discharges from hospital, people flagged by ambulance crews and NHS 111.
- Weekly MDT where cases are escalated to with input from the wider MDT. Actions/interventions agreed at MDT for what each person may require to improve their quality of life at home.

Integrated Improvement Programme – Priority 2

First contact/same day/Intensive conveyance avoidance

Virtual Ward

2. First contact, same day, intensive community response

P2.1 Oxfordshire Virtual ward team development

- **Rationale/benefits**: Assessments that would normally take place in the Emergency Department or SDEC can be delivered to the same standard in the patients own home.
- **Expectation**:
- Baseline skills assessment of clinicians working across the following teams, PML, H@H, OHFT H@H/UCR and OUHFT AOT teams
- Business case for the overall Oxfordshire Virtual ward team to include all H@H/UCR and key specialist teams
- Pathway development for key conditions
- Training and implementation of diagnostics across all clinical staff within e virtual ward team

P2.2 Virtual ward white board

- **Rationale:** There is one list of patients who are being monitored either remotely or face to face to maintain them safely at home – who would other wise be admitted to hospital
- **Expectation:**
- SOP for the administration of the Virtual ward white board
- A virtual ward whiteboard is kept up to date with all patients in the Oxfordshire Virtual ward
- Patients within the inclusion criteria for call before you convey are referred to and assessed by the most appropriate professional in the Virtual ward
- Patients within the Virtual ward are identifiable in their own home as being on the Virtual ward e.g. wrist band

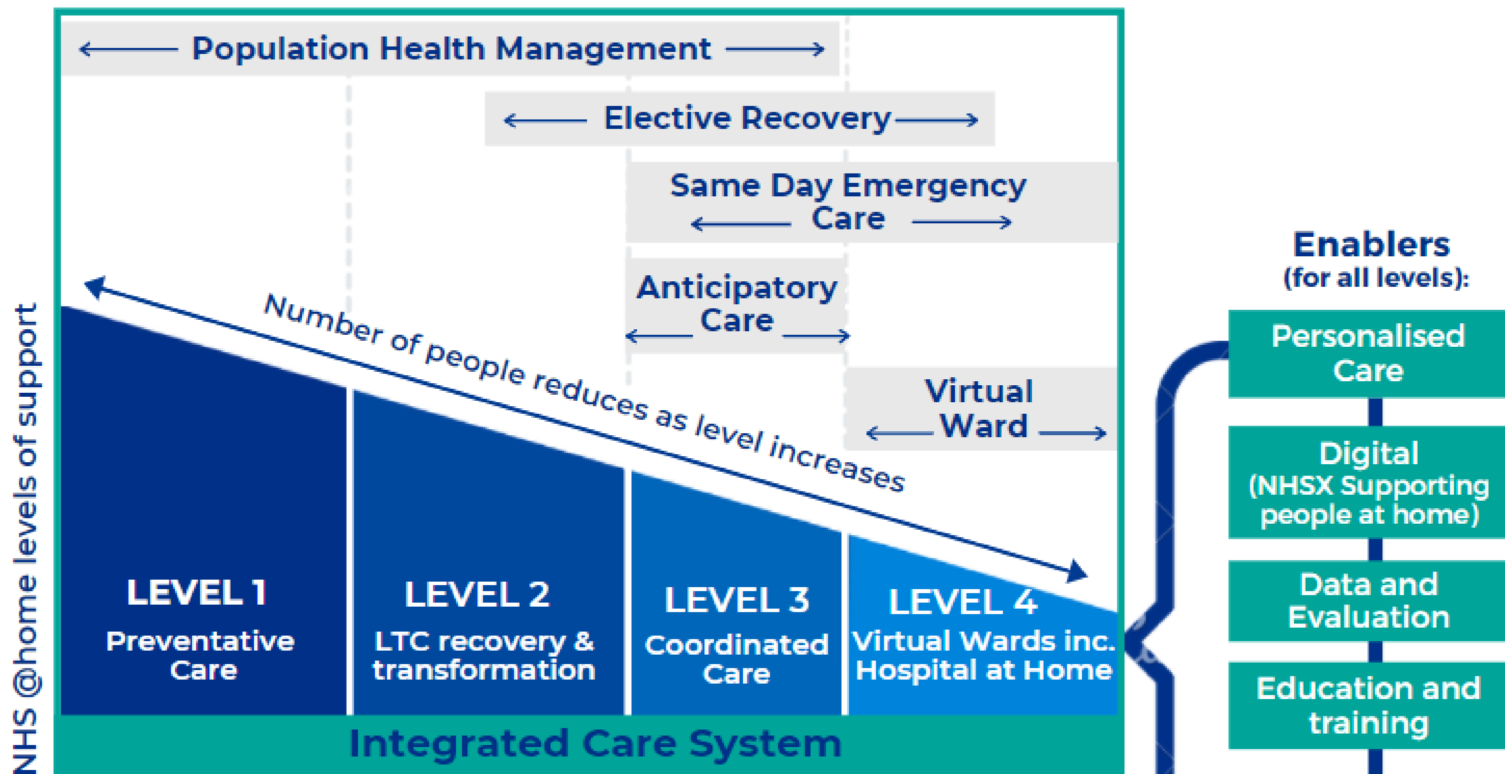
P2.3 Virtual ward MDT and reporting

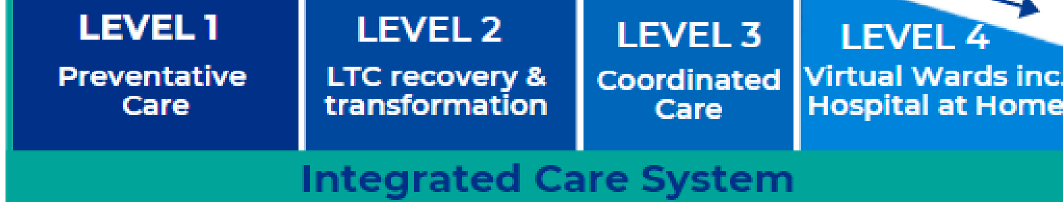
- **Rationale:** Medical and clinical oversight of patient on the virtual ward to maintain patients safely in their own home
- **Expectation**
- There is a minimum of a daily MDT, 7 days a week for all patient on the virtual ward
- The patient list on the virtual ward is maintained so it is up to date.
- Reporting needs to include those who are
  - monitored mostly remotely i.e. have face to face assessment/treatment but the majority is follow up via telephone or virtual review
  - Monitored mostly face to face with minimal follow up by telephone ro virtual assessment

NHS @home Operating Model

Personalised, connected and supported care at home, including care homes

Links with other key programmes





LEVEL 1: Whole population-based approach to supported, preventative self-care and wellbeing

LEVEL 2: Targeted, proactive support for people with long term physical and mental health conditions

LEVEL 3: Supporting people with complex care requirements and/or at higher risk of deterioration

LEVEL 4: Virtual wards support patients, who would otherwise be in hospital, to get the acute care, remote monitoring and treatment they need in their own home by providing an alternative to admission or enabling early supported discharge.

Integrated Improvement Programme – Priority 3

- **Patient flow and recovery**
- **Reducing the LOS of patients on the MOFD lists in beds across Oxfordshire**

3. Patient flow

P2.4 Minimising ambulance handover delays

- **Rationale/benefits**: 999 crews are released to assess other people.
- **Expectation**:
- 95% of ambulance handovers take place within 15mins of arrival
- Minimise the number of ambulance handover delays over 30 mins
- Zero delays over 60 mins
- Ambulance handover SOP is reviewed and signed off by system colleagues

P2.5 Reducing 12hr LOS in ED

- **Rationale:** Patients receive timely assessment, treatment and ongoing care in the most appropriate setting
- **Expectation:**
- Patients have a clinical assessment within 15 mins
- Clinical review by decision maker is carried out within 2hrs of the person arriving
- Increase the number of discharges per day 7 days a week across P0. P1. P2 and P3
- The majority of discharges take place before 12:00hrs
- Timely transfer of patients from ED to inpatient areas

P2.6 Same Day Emergency Care

- **Rationale**
- Patients who can remain at home are supported to do so and those who require further assessment are referred to the directly to the speciality
- **Expectation**
- HCP's across Oxfordshire have direct access to key specialities when a discussion is required about a patient
- There is a direct referral process when the HCP has made a clinical judgement that the patient needs to be seen in secondary care
- Specialities: Gynae, Urology, breast, ENT, plastics, Gastro, surgical emergency Unit and Medicine

3 Reducing the LOS for patients who are waiting for discharge across Oxfordshire beds

P3.1 Increasing the number of patients returning to their own home either on pathway 0 or 1

- **Rationale:** Patients who wish to and are assessed as safe to return to their own home should be supported to do so.

- **Expectation:**

- Increase the number of patients referred to return home with either no support or reablement / long term care.
- Develop demand and capacity model that meets existing demand and expected increase in demand
  - Increase capacity within reablement to meet the existing demand and future plan for potential increase in demand
- Meet national percentage guidelines or the number of patients discharged home on pathway 0 and 1

P3.2 Home First D2A

- **Rationale:** Reduce LOS in bed-based care by implementing D2A in line with national guidance for home and bed based Discharge to Assess.

- **Expectation**: People's care and reablement needs are assessed in their own home.
- The MDT describes what the patients can do and not prescribing the level of care required based on an assessment from bed based care.

- Patients in ED and assessment areas are supported to return home via the virtual ward or reablement pathway

P3.3 Reduce LOS in Pathway 1 and 2

- **Rationale:** A reduction of LOS in bed based and reablement a home creates more capacity to support more people being discharged from secondary care and improving flow through the emergency departments and assessment areas.

- **Expectation**: Reduce LOS in bed based rehabilitation to 21 day

- Reduce LOS in home based reablement to 21 days followed by a reduction to 14 days

Integrated Improvement Programme –Priority 4

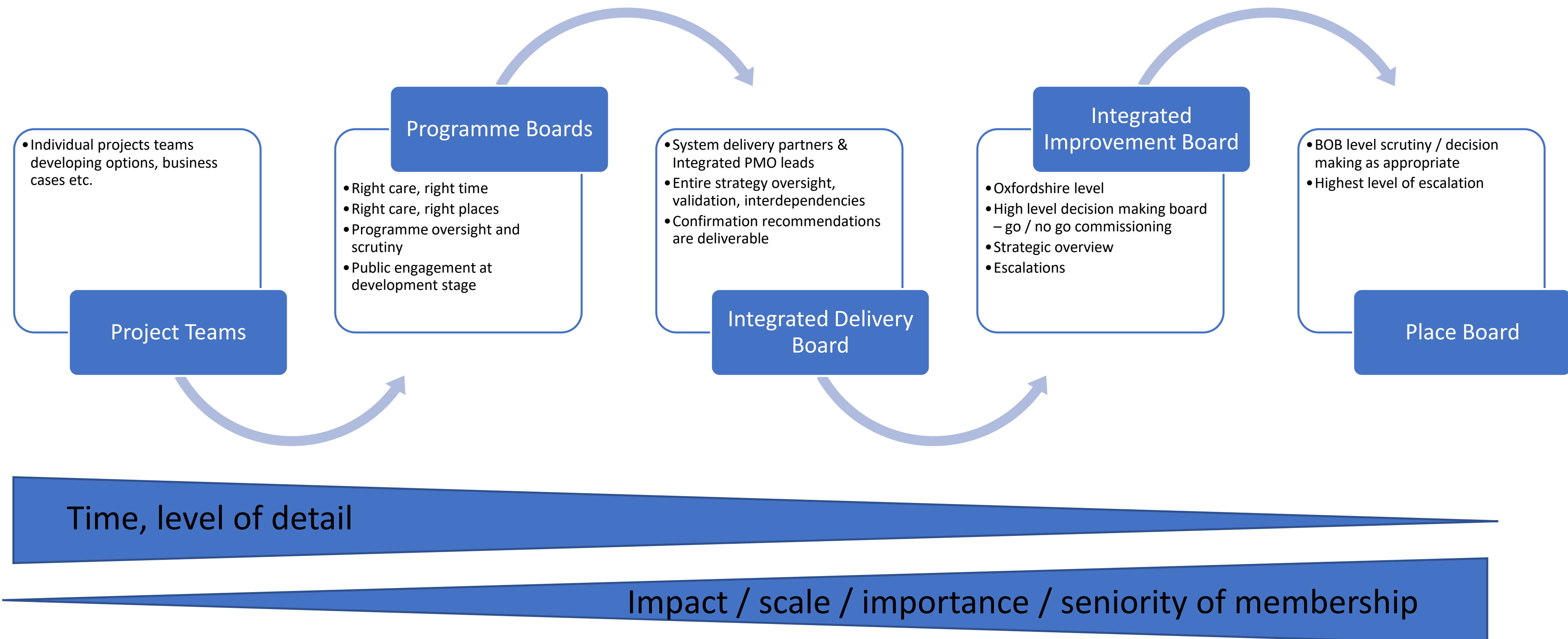
- **Governance reporting and strategic decision making**

OXFORDSHIRE
COUNTY COUNCIL

Approvals and flow

Enabling rapid decision-making and scrutiny appropriate to scale / importance of decision.

This streamlined approach is being finalised with ICS colleagues and will be discussed in more detail with JHOSC members at a special community services strategy meeting during the summer (proposed for July).



Questions?